# Evaluation of the Quality & Nursing Team Peer Review Programme

Dr Axel Kaehne, Dr Tom Simcock,
Alan Boyd, and Julie Feather
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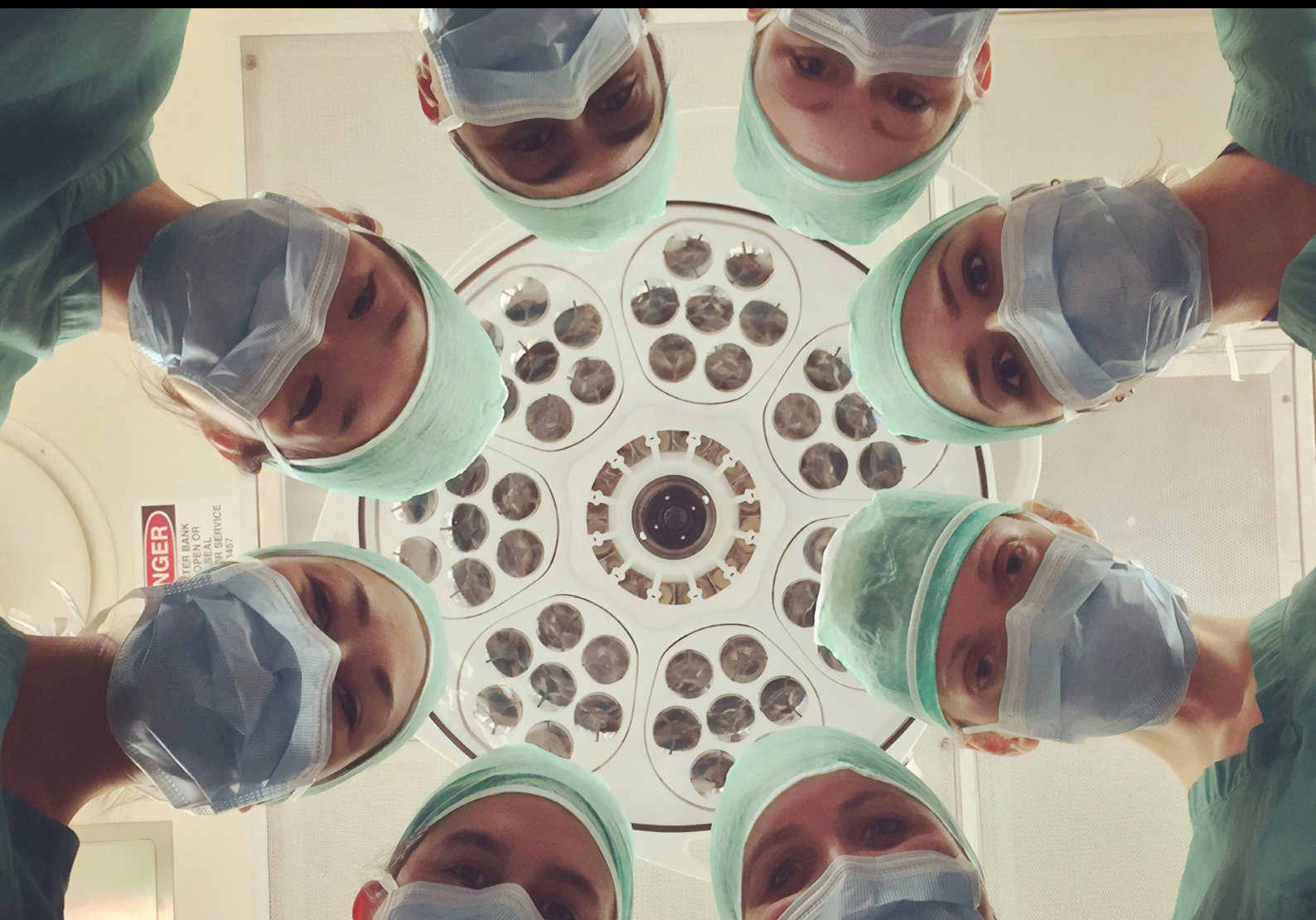
Edge Hill University

EPA
Unit for
Evaluation &
Policy Analysis

MANCHESTER 1824
The University of Manchester



# Evaluation of the Quality & Nursing Team (QNT) Peer Review Programme

**June 2021**

Dr Axel Kaehne[1]
Dr Tom Simcock[1]
Alan Boyd[2]
Julie Feather[3]

[1]Unit for Evaluation and Policy Analysis, Edge Hill University
[2]Alliance Manchester Business School, University of Manchester
[3]Department of Social Work & Interprofessional Education, University of Chester

## Acknowledgements

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# Executive Summary

The NHS England and NHS Improvement Quality & Nursing Team (QNT) commissioned the Unit for Evaluation and Policy Analysis (EPA) at Edge Hill University in collaboration with Alliance Manchester Business School, University of Manchester to conduct an evaluation of the QNT peer review programme. Building upon previous research, the aim of this evaluation was to obtain a picture of the effectiveness, strengths, and weaknesses of the peer review process and the feedback regime. The evaluation addresses the following questions:

1. Is the current peer review regime effective in helping services to improve?
2. How can the current peer review process be improved?

To undertake this evaluation and address the evaluation questions, the evaluation was split into two phases. The first phase focused on identifying and developing the logic model of the programme, understanding the experiences of those undertaking peer-reviews and the views of services that have been peer-reviewed. In this phase, 17 semi-structured interviews were undertaken with a range of participants, including members of the QNT team, peer reviewers, and services that had been peer reviewed. The data from these interviews were analysed using thematic analysis and integrated against the Impact Domain Framework. The second phase focused on the refinement and validation of the model through two workshops with Directors of Nursing and Service Commissioners. The data from the workshops were analysed using thematic analysis, with the themes integrated into the framework. Drawing upon the logic model for the peer review programme, the analysis from phase one and two, and the Consolidated Framework for Implementation Research, we developed key conclusions and positive recommendations for change for the QNT peer review programme.

## Key findings and conclusions

We critically compared the key findings from the 8 impact domains with the components of the peer review logic model to develop two key strands of findings on strengths and areas for improvement of the current peer review programme.

***Strengths of the current peer review programme***

There was clear evidence that the current peer review process focuses resources in reviewed services. The peer review process motivates some staff to review their processes and critically assess them against the standard of care encapsulated in the relevant guidelines and KPIs. This was a clear positive and staff indicated that the announcement of an impending peer review allowed them to deploy resources for improvement that were previously unavailable. There was also a clear consensus emerging in our analysis that peer review as an interaction inevitably exposed services to outside expertise and knowledge. This was perceived to result in useful and impactful exchanges between peer reviewed staff and peer reviewers. In sum, our analysis shows that the current peer review programme is clearly effective, albeit its main effects are materialising through compliance logics rather than peer review logics.

***Areas for improvement***

The current peer review programme appears to operate through a logic of compliance and thus inhibits the type of positive change that arises from forming relationships of mutual trust, which trigger reciprocal learning. Peer reviews are often perceived as compliance exercises

and lead to defensive reactions at least initially by some staff. This inhibits the development of genuinely productive and constructive relationships marked by mutual respect and an acknowledgement of equal validity of perspectives. The limited time a peer review team spends on location with staff then further impedes the development of positive relationships which are essential to maximising the learning processes supposed to be generated by the visit of peers.

Logics of compliance also reduce staff motivation to learn and change, and thereby diminish the potentially positive impact of peer review for the reviewed service. Meaningful engagements between peers are more likely to grow out of peer review approaches marked by 'deep dives' rather than brief exchanges during a single day visit.

## Our recommendations

Based on the findings and conclusions of this evaluation we have developed two broad areas of recommendations. These recommendations are situated, firstly, in modifying the current programme, and, secondly, in transforming the peer review programme.

- ***Modifications to existing peer review regime***
  - Put in place monitoring and training for all staff to ensure fidelity of peer review delivery across regional hubs
  - Review production and updating of KPIs in line with best practice
  - Consider format and mechanism for more effective shared learning on best practice
  - Consider more effective dissemination routes of final reports
  - Review possibility to publish final reports
  - Focus peer review visit interaction on a select number of pre-defined issues
  - Increase time and opportunities for interaction and informal exchanges during peer review visits
  - Provide for flexibility within the peer review programme to allow different SOPs for small clinical networks and larger ones (Cancer)

- ***Transformation of peer review regime***
  - Co-produce a new peer review process with key stakeholders
  - Separate out compliance and quality improvement components of peer review
  - Establish a QNT compliance arm – including a review of services failing KPIs
  - Establish a QNT peer review arm – aligned with the validated logic model
  - Develop peer review around principles of supporting quality improvement through reciprocal learning processes between reviewed staff and peer reviewers
  - Place system and organisational learning at the centre of peer review

# 1. Introduction

The NHS England and NHS Improvement Quality & Nursing Team (QNT) has commissioned the Unit for Evaluation and Policy Analysis (EPA) at Edge Hill University in collaboration with Alliance Manchester Business School, University of Manchester to conduct an evaluation of the QNT peer review programme. This project builds upon previous research EPA have undertaken for the QNT team, including a Literature Review on Peer Review Processes and an Evaluability Assessment of the peer review programme. This report sets out the findings of the evaluation of the QNT peer review programme.

## 1.1 Background to the QNT Programme

NHS England and NHS Improvement monitors the quality of all specialised commissioned and cancer services in England. The Quality & Nursing Team (QNT) plays a crucial part in assessing the quality of those services and has developed a QNT Framework to discharge these responsibilities.

### 1.1.1 QNT framework

The QNT framework uses defined metrics to collect information from each provider on an annual basis through a self-report process, with the option to follow this up with a peer review process. The report is based on quality indicators that are aligned to the six programmes of care in England and reflect the particular service specification. The self-report process allows QNT to obtain relevant data through an established Quality Surveillance Information System (QSIS) where categories are populated by service responses, then collated centrally and analysed by regional hubs. Aggregated reports for services are then reviewed, and actions are agreed following engagement with commissioners and service leads. Additional surveillance actions are expected where services score less than 100 per cent of their service's previously agreed quality indicators or fail their good practice compliance threshold. Three types of actions are possible:

- Option 1 is routine surveillance.
- Option 2 is enhanced surveillance, involving either provider or commissioner action, or both.
- Option 3 is peer review.

Options can be combined depending on the level of risk assessed by QNT in consensus with the provider and commissioner of a specific service. QNT developed a Standard Operating Procedure (SOP) for their peer-review process. This SOP outlines the objectives, processes, and the responsibilities of everyone involved.

## 1.2 Literature review and evaluability assessment findings

The QNT team previously commissioned the project team to undertake a literature review on the current evidence base on peer review processes (Kaehne, et al., 2019) and an evaluability assessment of the QNT programme (Kaehne and Simcock, 2019). The literature review project identified that peer review processes remain insufficiently evidenced and differ considerably in their aims and objectives and their intended impact. A key finding of this research was that peer review processes suffer from poorly articulated models of change or logics of intervention that can be tested and refined.

The evaluability assessment found that a reliable and credible evaluation can be undertaken of the NHS England and NHS Improvement QNT programme (Kaehne and Simcock, 2019). Based on the findings of this assessment and the previous literature review, we have identified four programme domains that the evaluation would need to examine:

1. The aims and objectives of the peer review process (the 'what');
2. The intervention itself (the 'how');
3. The theory of the intervention (the 'why should it work'); and,
4. The staff involved in the process (the 'who').

These relate to four investigative areas: the logic of intervention and development of appropriate measures of success; the role of peer reviewers and staff and their expectations; the fidelity of peer review practice across the programme; and the influence of the broader policy context.

The project team further identified that there has been some research within the wider quality improvement and safety context which has produced, amongst other things, an Impact Domain Framework (Smithson *et al.* 2019) detailing potential impact mechanisms for external reviews to produce quality improvement (see Appendix).

## 1.3 Evaluation Aims

The aim of this evaluation is to obtain a picture of the effectiveness, strengths and weaknesses of the peer review process and the feedback regime. The evaluation addresses the following questions:

1. Is the current peer review regime effective in helping services to improve?
2. How can the current peer review process be improved?

# 2. Method

To undertake this evaluation and address the evaluation questions, the evaluation was split into two phases. The first phase focused on identifying and developing the logic model of the programme, understanding the experiences of those undertaking peer-reviews and the views of services that have been peer-reviewed. The second phase focused on the refinement and validation of the model through workshops with Directors of Nursing and Service Commissioners.

The Impact Domain Framework mentioned above functioned as a starting point for producing a programme specific *Model of Impact* for QNT peer reviews. In phase two, this Model of Impact was validated and applied to identify strengths and weaknesses of the current practice of peer review visits to produce robust recommendations for improvement of peer review practice.

## 2.1 Data-collection and analysis

### 2.1.1 Phase One: Development of the logic model

The project team undertook a series of semi-structured interviews (n=17) to investigate the current peer review process. Participants included QNT team members, service commissioners, and front-line staff members who had acted as a peer reviewer in the past (a breakdown of participant demographic information is provided in table 1 below). Some participants were from more than one category, for example having experience of being a peer reviewer and being a front-line staff member of a service that had been peer reviewed. The sampling of the participants across the different groups was facilitated by the NHS QNT team.

***Table 1.*** **Number of participants by type of participant**

| Professional group | Number of participants |
|---|---|
| NHS QNT staff member | 4 |
| Front-line staff | 5 |
| Service manager | 4 |
| Service commissioners and stakeholders | 3 |
| Patient Peer Reviewer | 1 |

All interviews were conducted online using Microsoft Teams or Zoom at a time convenient to the participants between September 2020 and January 2021. A semi-structured approach was followed, with the evaluators utilising an interview schedule and exploring concepts and responses in more depth throughout the interviews. The interviews lasted between 20 and 45 minutes and were on average approximately 30 minutes long.

All of the interviews were recorded with the consent of the interviewee, transcribed and anonymised. The anonymised interview transcripts were then analysed using Thematic Analysis (Braun and Clarke, 2006). For the analysis, two researchers read through the transcripts independently and identified initial codes. These codes were then compared and refined into a number of key themes. Disagreements were resolved through discussion and

consensus. The themes were then integrated and examined against the Impact Domain Framework to enable new insight into the QNT peer review process.

### 2.1.2 Phase Two: Refinement and validation of the logic model

The aim of the second phase of this evaluation was to refine and validate the logic model of the programme developed through the first phase. Broadly speaking, we draw on theory-based approaches in evaluation, such as Theory of Change models, which have emerged over the last decade. A Theory of Change or logic model is an illustration of why a particular intervention should work and how. It identifies the 'active ingredients' of the intervention (what is doing the work) and the conditions under which they become activated or remain dormant. Theory of change approaches reveal assumptions programme makers made about the intervention they designed on how the intervention is supposed to work, why and under which circumstances. Theories of change are tested and validated with emerging evidence from interviews. This last step allows evaluators to identify strengths and weaknesses of the intervention and formulate robust recommendations for change.

In the case of this evaluation, we developed a logic model for peer review as practiced by QNT currently, and then contrasted it with the emerging evidence from our interviews and workshops. This provided us with insights about how the main principles of peer review differed from the current model applied within the QNT Peer review Programme. These insights gave us the critical perspective which underpins our conclusions and recommendations.

In this second phase, two workshops were undertaken with Directors of Nursing and commissioners of services in May 2021. These workshops were conducted online using Microsoft Teams at a mutually convenient time to the participants. The workshops lasted between 1hr 30 and 2 hours. The workshops were recorded with the consent of the participants, transcribed and anonymised. The anonymised interview transcripts were then analysed using Thematic Analysis (Braun and Clarke, 2006). For the analysis, two researchers read through the transcripts independently and identified initial codes.

These codes were then compared and refined into several key themes. Disagreements were resolved through discussion and consensus. The themes from the workshops were integrated into the existing themes and framework. The validated logic model assisted us in generating basic principles of peer review, which constituted an ideal model of what peer review should be. We then mapped the emerging evidence from our phase 1 and 2 against this set of principles which gave us the critical distance to the current peer review regime of QNT and allowed us to formulate recommendations and suggestions for positive change.

Whilst our evaluation was underpinned by a logic model which supplied the main evaluative steps in our work, we were conscious of the fact that QNT operates within a complex field of intersecting factors such as wider NHS policy in the commissioning, quality improvement and regulatory field. We therefore also applied a general interpretative framework, the Consolidated Framework for Implementation Research (CFIR) to ensure that contextual factors were integrated into our critical analysis. Broadly speaking, this interpretative framework refers to four domains that require attention and interpretation: outer setting, inner setting, intervention characteristics, characteristics of individuals (staff). Using CFIR in our evaluation ensured that we would not overlook the outer policy setting which we believe strongly influences QNT peer review processes.

# 3. Findings of Phase one: development of logic model

This report briefly summarises the main findings from phase one of the Quality & Nursing Team Programme (QNT) evaluation. Data analysis of semi-structured interviews with key stakeholders was guided by the impact framework (Smithson et al., 2018) which contains eight impact domains of anticipatory, directive, organisational, relational, informational, stakeholder, lateral and systemic. These impact domains have been used to structure the findings below.

## 3.1 Anticipatory

Anticipatory impact involves the process of QNT peer review, setting quality expectations, and providers' understanding of those expectations and seeking to comply in advance of any interaction with the QNT (Smithson et al., 2018). The process for providing and submitting documentation to the QSIS portal was clear for participants. However, one participant commented that they had been uncertain of processes prior to the peer review visit and decided to seek support from another service that had undergone peer review. Several participants described how time-intensive the preparation stages of the peer review were and how this impacted on their day-to-day work. Rapid reviews were highlighted as an area that required improvement as they generally took a significant amount of time to organise. Overall, participants suggested that the peer review was focused on assessing services against the quality indicators, which for some were not a reliable measure to benchmark quality against:

> *"… the assessment is made against compliance, against those which have been set down previously and some of which may or may not be entirely up to date and relevant… So it's a little bit rigid in some senses that there are external factors that weren't taken into account and so I think because it's … you have to have fixed criteria to be assessed against but when those are out of date, the criteria, the system doesn't necessarily have a way of coping with that" (FLS 01).*

## 3.2 Directive

Directive impact refers to providers taking actions that they have been directed or guided to take by the peer review team (Smithson et al., 2018). Findings show that there was some confusion over who was responsible for taking ownership of the action plan and ensuring that actions were taken by providers. Several participants stated that their ability to implement recommendations were at times hindered by a lack of resources. Some participants were also unsure what the next steps were once they had received the report:

> *"I think the challenge… is around once you've done the peer review, how are you then going to make sure that those improvements are made… I'm not overly clear that we know what the next steps are. I think obviously there's feedback to the teams, and obviously it's gone to the chief execs and so on, and obviously internally we'll all be trying to make some improvements based on the report. But I think for our particular service, I don't think we know what the next steps are. Whereas normally with peer reviews and quality improvement programmes, you're having a period of time to make that improvement, and then you'll know when the next review's gonna take place. I think with the peer review, I don't think any of us know when the next one would be. So, it leaves it a little bit open ended as to*

*whether you feel it's a quality improvement or not, because you could have feedback and then not do anything with the feedback" (PR 01).*

## 3.3 Organisational

Organisational impact refers to internal organisational developments, reflection and analysis by providers that are in some way prompted by the peer review but are not related to specific directions (Smithson et al., 2018). For participants, being peer reviewed by experienced clinicians who understood specific conditions and how services worked was a positive aspect of the peer review process. This facilitated the sharing of knowledge and experience and provided a mechanism for participants to critically examine and reflect on their practices identifying where changes were needed. However, in smaller, more specialist services peer on peer review created some concerns as peer reviewers were often known to services and it was felt that may create intra-professional challenges.

Good examples of informal opportunities for shared learning were described by several participants, however these related more to peer reviewers learning from services being peer reviewed rather than the other way around. There was evidence to support improvements to practice as a direct result of the peer review process, however for some providers it was more about evidencing processes rather than improving service quality itself:

*"We have managed to tick all those things off and we have got the paperwork for that but if they told me there were coming tomorrow I would be like, oh my god, not everything is in the right folder, in the right place, I'm going to have to sit and sort all of that out again but its more than a four lined email now, it is a SOP and pathways and those essential things but it hasn't really changed anything in the way we deliver our service, its literally just writing down stuff on a bit of paper…" (QNT 04).*

## 3.4 Relational

Relational impact results from the person-to-person interactions between peer reviewers and those being peer reviewed. Informal, soft, influencing actions have an impact on providers (Smithson et al., 2018). Several participants discussed the positive value in 'peer on peer' review. They appreciated the matching expertise between the reviewers and the reviewed service and thought this to be an important aspect of peer reviews. They highlighted that peer review could be seen as a quality improvement tool, a compliance tool, or both. However, the way peer reviewers conceptualised the visit was seen to influence actions taken by providers:

*"It certainly did feedback on some occasions that there need to be change so it wasn't soft in circumstances, but it didn't provide expertise in how to do it. It just said this needs to be done for your service kind of thing" (QNT 05).*

Having an understanding and knowledge of the geographical area in which services operate was also seen to be important. Peer reviewers who were unfamiliar with the local context at times made comparisons with their own services which providers felt to be unfair:

*"Yes, so you've got somebody who, you know… has to transport patients for four or five hours, where that's not something that, you know, L [city] would ever do,*

*and were very critical of things that were out of the trust's control because of the geography" (COM 01).*

## 3.5 Informational

Informational impact results from collating and sharing information within the public domain or other actors who then use it for decision making (e.g. commissioning, patient choice) (Smithson et al., 2018). Participants commented that peer review reports were perceived as very positive at times and useful. They were however not shared with the public or external providers and there is no formal mechanism for sharing learning between different providers. One participant stated that specialised commissioning completed their own reports which are fed back to the quality surveillance group:

*"I think there is nowhere for comparison for trusts to see each other's reports so once that final report goes back to the organisation then it's not seen, it's not held publicly anywhere or anywhere within NHS England where other people can actually dip in and see them and I feel that they're useful for other members even within the team" (QNT 03).*

## 3.6 Stakeholder

Stakeholder impact refers to the actions taken by peer reviewers which encourage, mandate or influence other stakeholders (such as patients), to take action or interact with peer reviewed organisations (Smithson et al., 2018). Respondents felt that the patient perspective was to an extent insufficiently articulated within the peer review process. The peer review team itself did have patient representation, however patients using services that were not actively involved in the process:

*"I think it's very crucial to include patient perspectives in the reviews and I think we are missing that because we do have patients [on the review team] that come in but don't have a relationship with the staff who work in the service. It is more important to hear from the patients who are actually using the service" (QNT 06).*

## 3.7 Lateral

Lateral impact results from peer review interactions that stimulate inter-organisational interactions, such as providers working with their peers to share learning and undertake improvement work (Smithson et al., 2018). Opportunities for shared learning were limited as peer review reports were not available for other providers to access and there was no formal mechanism in place to share learning between different providers:

*"So I don't think there's been and I'm not aware at the moment of a process by which for example the reports from the different centres are shared or discussed in terms of looking at them together… I don't think there is a process in place at the moment for how the individual services are going to learn unless there was a mechanism put in place by which there was suggested shared learning perhaps from the review of all of the services" (FLS 01).*

*"[What we would want to see is] almost reciprocal learning because you've got four or five centres and each is presumably going in and supporting the other, that*

*is, you're right, I think you can sort of see more of a value" (Workshop participant 01)*

## 3.8 Systemic

Systemic impact refers to aggregated findings/information from peer reviews being used to identify systemic or inter-organisational issues, and to influence stakeholders and wider systems other than the providers who have been peer reviewed themselves (Smithson et al., 2018). There was little data to support systemic impact. One participant stated that information from peer reviews was being shared with CQC, however this was done informally:

> *"… the way we work with CQC is they do use our information. CQC like to have more broader hospital information and they would like us to have a more of a traffic light system in terms of where we thought somebody was good, bad or indifferent or whatever we want to say… So that doesn't always lend itself to what peer review use, but they certainly get our reports they asked for a breakdown every year of certain services and we provide it to them. So we do work with them" (QNT 02).*

Several participants commented that the main impact of QNT on services was to ensure equality of service provision through applying service standards. However, wider comparison and learning between different providers was limited due to reports not being available to both the public and external providers.

Respondents did think that peer review should have a systemic impact however. They also indicated that this may be difficult to measure within the current processes yet there was clearly a desire to maximise systemic learning.

> *"[The issue is] how do you feed this information into the wider intelligence about providers. You cannot have alarm bells ringing in one part of the system if actually some of that issue is around governance or leadership, because that has implication on all services, even if specialised commissioning, don't pay the bill." (workshop 02)*

# 4. Findings of Phase Two: Refinement and validation of the logic model

Following our analysis of the interview and workshop transcripts we developed a preliminary logic model for peer review. First, however, we set out below the wider context (outer setting) of the QNT peer review programme first, before we then sketch the logic model as an interplay between the inner setting, the intervention characteristics, and the individual characteristics.

## 4.1 Wider Policy Context of QNT peer review programme

The tension of purpose between quality improvement and regulatory compliance sets the tone for the peer review programme in the wider NHS policy context. Policy development poses significant leadership challenges to QNT staff in defining the exact function and capacity of peer review in the wider health service and regulatory landscape. In particular, five external factors of particular importance have been identified through our data analysis: the formation and ongoing development of integrated care systems (ICS); the further transformation of specialised commissioning through NHS England and NHS Improvement and the trend towards devolved regional commissioning; the wider emerging quality improvement agenda in NHS England and NHS Improvement; the leadership context of health service delivery and, finally, the threats to routine processes by the COVID pandemic. We will outline the challenges posed by each factor in the section below.

### 4.1.1 Integrated Care Systems

As the NHS in England has embarked on significant changes marked by ongoing devolution of budgets and control to Integrated Care Systems, our data shows that this is perceived by respondents as an important influencing factor in delivering effective peer review. ICS is widely seen as a shift of control from central NHS England and NHS Improvement to local and regional systems in terms of planning, delivering and quality assuring health services. QNT peer review is affected by this shift since commissioning specialised services and reporting of peer review are likely to undergo changes reflecting the migration of control from NHS England and NHS Improvement to ICS. Respondents reflected on this in the workshops.

> *'So we want to use the networks to drive improvement around pathways for specialised services, but we want the ICS is to have an overview of risk.' (Workshop 1)*
>
> *'So the systems, the ICS, must take the lead, they have to take the responsibility.' (Workshop 2)*
>
> *Should hospitals and ICSs have an approach to quality improvement and population health? Yes, absolutely. Should it be different for specialised services within the ecosystem of the locality? No, I don't think so.' (Workshop 2)*

### 4.1.2 Specialised Commissioning

A second aspect that was articulated by our respondents related to the changes in specialised commissioning. The processes and protocols of QNT peer review are currently aligned with the specialised commissioning landscape which is undergoing significant changes. Developed originally as an instrument of quality improvement and compliance in cancer services, the peer review programme retained the approach from this initial clinical

area and widened its application to other specialised commissioned services that were brought into the remit of NHS England and NHS Improvement through the Health and Social Care Act (2012). Closely aligned with the existing commissioning structure, respondents thought that the peer review programme is likely to face considerable challenges as some of the commissioning tasks are migrating to other parts of the health care system.

> *'I …the drawing distinctions between what is a specialised service and not a specialised service [is problematic] because of course patients go through a range of specialised and non-specialised services as part of their care journey so wouldn't it be better to look at the hospital or the ICS in totality and have a targeted and coherent approach to QI generally rather than just specifying something for one type of service and something else for another? (Workshop 2)*

> *'So the nursing of quality directorates, there are different Directorate just to confuse things they I sit in direct commissioning, they are headed up by the regional Chief Nurse have the regulatory responsibilities of oversight of CCGs and M trusts. And therefore, I would want to use that part to inform their broader view of a provider or a particular risk. Yeah, so I think for me, there's something about other commissioning functions outside of specialist commissioning.' (Workshop 1)*

### 4.1.3 Quality Improvement Culture

Over the last decade the NHS in England has moved to a model of continuous and systematic innovation and transformation of its services. Quality improvement is written into its service DNA and peer review in general and the QNT peer review programme specifically is thought to play an important part in this. What is less clear however is how the location and driver of quality improvements and the incentive structure for service changes bringing about improvement for patient care align with the QNT peer review programme. Many service improvements occur at team level, often driven by individual staff's desire to develop better services for patients.

At an organisational level, trusts often take advantage of large innovation and improvement programmes such as the Vanguard Programme New Models of Care which comes with additional funding. The quality improvement agenda is also connected to shared learning processes which take place in clinical networks. Respondents thought it critical for the QNT peer review programme to ascertain its exact role in these quality improvement processes by pinpointing the contribution it can make at which level. To maximise its impact in this field, our respondents were adamant that peer review had a role to play as and where its remit was clearly defined.

> *'I think there should be more focus on the quality improvement, so having done some peer reviews with the team myself, often I've found it very sort of process-driven that - I don't know, it just lacks any sort of personalisation because it's basically a bit of a tick box' (Workshop 1)*

### 4.1.4 Leadership

The NHS has invested heavily in the development of leadership skills and competencies of its workforce. A key driver for service improvements is thought to be good leadership by clinical and management staff. More recently, the NHS leadership model has advocated for

all staff to adopt attributes and behaviours of good health care leaders. As peer review is embedded in processes occurring at team and organisational level which require staff to navigate interprofessional boundaries, leadership skills were seen by respondents as a key building block for an impactful peer review programme.

### 4.1.5 COVID

At its centre, peer review contains a face-to-face encounter between those visited and their peer reviewers. Social distancing requirements and 'lockdown' in England due to COVID represented the biggest threat to the effective discharging of peer review obligations of QNT. Our respondents however clearly saw this as an opportunity as much as a challenge to the programme. As 'on site' peer reviews were suspended during the pandemic, questions about the nature of peer review, its feasibility within a COVID safe environment and possible alternatives arose. There was a strong view amongst respondents that all NHS services, including QNT peer review, need to develop models of working which are COVID secure insulating them from the effect of future pandemics. It was seen as paramount that COVID secure ways of working were built into the standard operating protocol as a matter of routine, ensuring that peer review was protected against any future pandemic.

The factors outlined above produce a wider setting of policy drivers and contingencies that is marked by significant uncertainties and continuous change. The QNT peer review programme will need to confront the challenges around these uncertainties head on if it is to build a robust, yet flexible and effective model of peer review aligned with newly emerging structures such as ICS, new specialised commissioning processes, and the wider Quality Improvement and leadership agenda which is still taking shape.

## 4.2 Logic Model

We developed our logic model for the peer review processes through the lens of main principles. They emerged from a close reading of our interview and workshop transcripts and led to the articulation of the theoretical domains that constitute an effective and impactful peer review. Having formulated this ideal model of peer review we then contrasted this with our findings from the current peer review analysis as captured by the 8 impact domains (sections above). In the section below we set out the main principles that underpin effective peer review, and then outline the various processes of the ideal model of peer review encapsulated in three 'active ingredients' of peer review or impact processes.

### 4.2.1 Main principles of peer review

Our analysis identified five principles that underpin any effective peer review. These principles aligned with the findings in our literature review (Kaehne et al, 2018) as well, even though there were few fully articulated models of peer review published as yet.

Any peer review to be effective has to be a type of **reciprocal learning**. This learning occurs at all four levels of potential impact, the individual (staff involved in the peer review on both sides), the team (the visited team as well as the peer review team), the organisation (the trust or service reviewed) and the wider system represented by clinical and management networks. Incentivising, encouraging and creating conditions that promote this reciprocal learning is a key factor in producing impactful peer reviews.

For peer reviews to be effective, they need to take place in conditions characterised by **equality of status, knowledge and expertise**. This does not mean that everyone has the same amount of clinical knowledge but there has to be a recognition of the utility and validity

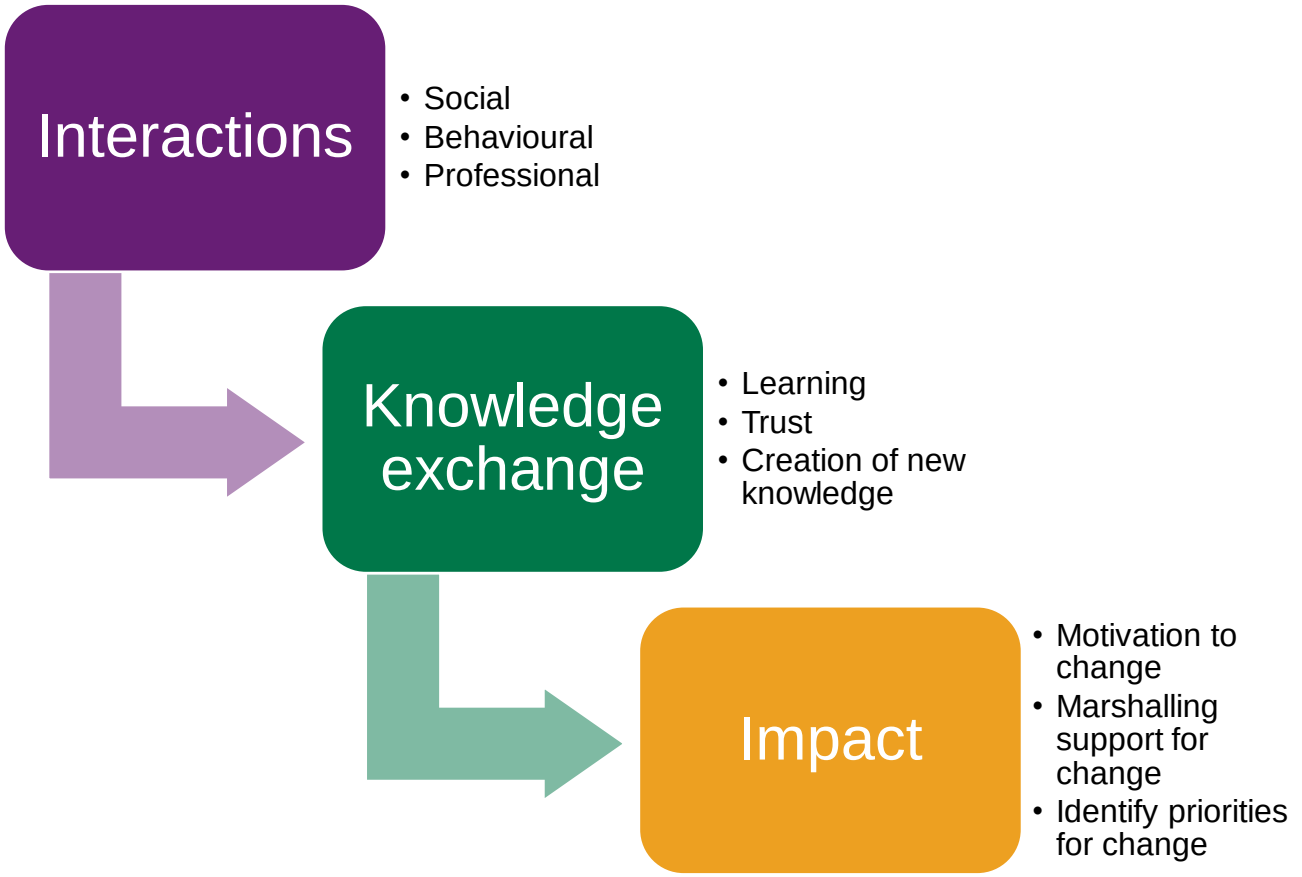
of all types of knowledge and expertise without privileging one over another. In essence, peer review requires the exchange of views and opinions unencumbered by notions of professional hierarchies, and different standing of knowledge. Acknowledging different perspectives in their validity is a key prerequisite for effective peer review. This applies to both peer reviewers and those being peer reviewed. Creating conditions under which this equality of status, knowledge and expertise takes place is a considerable challenge. It may require careful calibration of preparatory information and briefings for everyone involved. Setting the right tone is a good first step.

Distinct yet related to this is the idea that a peer review entails the **voluntary exchange of views, opinions and information** from both sides. This applies to the willingness to share information on the side of the reviewed service and its staff as well as to the attitude and approach from the team of peer reviewers. Effective peer reviews appear to be conditional on the voluntary nature of exchanges of information. The voluntary nature of engagement connects the interactions between peer reviewers and reviewed staff to the motivational resources of teams. Activating their willingness to share seems to be a key requisite to learn and hence for effective peer review.

On the flip side of this, peer reviews appear to be dependent on **collegial learning** in the absence of sanctions for failure or systemic weaknesses. There is strong evidence in the literature and in our data that where peer review is seen as punitive, learning effects fail to materialise (Herrington and Hand 2019; Rivas et al. 2012; Whitney et al. 2016). Where censorious or disapproving attitudes prevail, or are seen to dominate, learning appears to be inhibited. This has particular relevance with regard to the previously identified tension between compliance and quality improvement approach of the QNT peer review programme.

Last but not least, effective peer reviews appear to be made possible where **relationships of trust** exist. This requires time and effort to develop and points to the specific challenge of the current peer review programme where reviews take place within a single day visit. Mutual trust and respect may be difficult to emerge during brief events designed for simple exchanges of information.

The five principles of peer review helped us to critically think about the processes and conditions that need to exist at the various levels of interactions which usually take place during peer reviews. This led us to design a graphical demonstration of the change processes ideally occurring in peer reviews. The figure below captures our logic model.




As can be seen in the figure above there are three broad areas of processes in each peer review. There are, first, interactions between staff, which have a social, behavioural, and professional dimension. Second, there is a multitude of knowledge exchanges, stimulating learning, promoting the development of mutual trust and the creation of new knowledge. The latter is a collective process where knowledge is held by the individual staff as well as the team. Third, there is a multitude of possible impacts ranging from the motivation to change triggered by interactions and knowledge exchanges, the ability and desire to marshal support for change, as well as the identification of priorities for change in a service as well as amongst peer reviewers who bring to bear new insights on their own services.

We also indicated in the figure that these processes are occurring at each level, individual, team, organisation, and system, albeit to a different degree. Following the development of the logic model we then applied it to our findings from the data analysis. We critically compared and contrasted the messages from the 8 impact domains with the components of the peer review logic model to draw conclusions about the strengths and weaknesses of the current iteration of peer review.

### 4.2.2 Strengths

There was clear evidence that the current peer review process focuses resources in reviewed services to identify strengths and areas for improvement. The peer review process motivates some staff to review their processes and critically assess them against the standard of care encapsulated in the relevant guidelines and KPIs. This was a clear positive and staff indicated that the announcement of an impending peer review allowed them to deploy resources for improvement that were previously unavailable.

There was also a clear consensus emerging in our analysis that peer review as an interaction inevitably exposed services to outside expertise and knowledge. This was perceived to result in useful and impactful exchanges between peer reviewed staff and peer reviewers.

These positive messages related to the impact of peer review, yet appeared to be partially disconnected to the interaction and learning dimension of the logic model we formulated. This means that those gains were realised independent of robust foundations of trust and collective learning processes which were to be the basis for sustainable and lasting change in peer reviewed services. In essence, our analysis shows that the current peer review programme is clearly effective to some extent with its main effects materialising through compliance logics rather than peer review logics.

### 4.2.3 Areas for improvement

That the current peer review programme appears to operate through a logic of compliance inhibits the type of positive change that arises from forming relationships of mutual trust, which trigger reciprocal learning. In short, the principles underpinning learning processes on both sides are failing to materialise to a large extent in the peer review programme. Peer reviews are perceived as compliance exercises by many, and lead to defensive reactions at least initially by some staff. This inhibits the development of genuinely productive and constructive relationships marked by mutual respect and an acknowledgement of equal validity of perspectives. The limited time a peer review team spends at a service and with staff then further impedes the development of positive relationships which can encourage staff to maximise the learning processes supposed to be generated by the visit of peers.

In our view, at the heart of this lies the tension between the perception of QNT peer review programme as a compliance procedure and its aspiration as a quality improvement process. The logic of compliance rests on sanction and punitive action whilst the quality improvement model is built on mutual learning, positive leadership and motivation of staff to introduce changes voluntarily and embed service improvement into the delivery of patient care. The failure to comply reduces staff's motivation to learn and change, and thereby diminishes the potentially positive impact of peer review for the reviewed service.

To deflect this reactive and defensive approach induced by compliance, peer review should instead rely on the willingness of staff to learn, drawing on their own resources to initiate positive change. Peer reviews should instigate this process of change by prompting staff in reviewed services to learn rather than simply comply with pre-defined standards of care.

Shifting the peer review process away from the compliance model to a more ambitious yet unrealised quality improvement tool, peer reviews would need to create conditions for collegial dialogues and conversations between peers rather than working through checklists of KPIs. These dialogues are indicative of meaningful engagements which are more likely to grow out of peer review approaches marked by 'deep dives' rather than brief exchanges

during a single day visit. Moving away from specific standards of care may also speak to the changing specialised commissioning landscape and the emergence of ICS in the NHS, where patient pathways gain increasing importance.

We have summarised key points of our critical analysis below.

- *Principles of peer review are at odds with 'logics of compliance';*
- *Peer review should be activated by willingness to learn rather than failure to comply*
- *Peer review is a means to initiate dialogue within the system;*
- *There should be meaningful engagement based on 'deep dive' approach rather than a brief single day visit; and,*
- *The assessment framework should prioritise quality of service and patient pathways.*

## 5. Conclusions

The future of peer review at QNT is influenced by important changes in the wider regulatory and commissioning landscape. Whilst our evaluation assessed 'what works' in the current model of peer review, we are conscious that recommendations need to be cognisant of external changes for the organisation and its remit. Changes to specialised commissioning, the ascent of ICS, and COVID, combine to pose a significant challenge to QNT's peer review processes. However, they also represent a considerable opportunity to create an effective peer review model that speaks to the complexity of quality improvement in health care services.

Given the dual nature of challenges, reflecting external and internal factors, we make suggestions for change of different scope and reach. We have couched this in terms of a 'modification' or 'transformation' approach. This allows us to split our recommendations. The first set of recommendations applies to the narrower confines of peer review itself, proposing modification to bring the current peer review processes more in line with the logic model articulated above.

Our second set of recommendations however aims for a wider and more radical transformation of QNT's peer review programme. It sets out a framework based on the nature of quality improvement as advocated by NHS England and NHS Improvement. We make these suggestions in the spirit of QNT's ambition to create a peer review process that optimises the positive impact on the services to be reviewed. We recognise that this second set of recommendations is likely to take up considerable resources in the development of additional skills and expertise amongst its staff and peer reviewers, with a wholesale review of the Standard Operating Protocol. We do believe however that this represents a unique opportunity for QNT to design and implement a genuinely co-produced peer review model.

# 6. Recommendations

Based on the findings and conclusions of this evaluation, along with the findings of the previous literature review, we have developed several evidence-informed recommendations for the QNT peer review programme.

## 6.1 Modifications to existing peer review regime

- Put in place monitoring and training for all staff to ensure fidelity of peer review delivery across regional hubs
- Review production and updating of KPIs in line with best practice
- Consider format and mechanism for more effective shared learning on best practice
- Consider more effective dissemination routes of final reports
- Review possibility to publish final reports
- Focus peer review visit interaction on a select number of pre-defined issues
- Increase time and opportunities for interaction and informal exchanges during peer review visits
- Provide for flexibility within the peer review programme to allow different SOPs for small clinical networks and larger ones (Cancer)

## 6.2 Transformation of peer review regime

- Co-produce a new peer review process with key stakeholders
- Separate out compliance and quality improvement components of peer review
- Establish a QNT compliance arm – including a review of services failing KPIs
- Establish a QNT peer review arm – aligned with the validated logic model
- Develop peer review around principles of supporting quality improvement through reciprocal learning processes between reviewed staff and peer reviewers
- Place system and organisational learning at the centre of peer review

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# Appendix

## Appendix 1: Impact Domain Framework (Source: Smithson et al., 2019)

| Impact mechanism | Description of logic/causal chain/process |
|---|---|
| **Anticipatory** | *The peer review sets quality expectations, and providers understand those expectations and seek compliance in advance of any review interaction.* |
| **Directive** | *Providers take actions that they have been directed or guided to take by the QNT.* |
| **Organisational** | *Peer review interaction leads to internal organisational developments, reflection and analysis by providers that are not related to specific directions. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.* |
| **Relational** | *Results from the nature of relationships between QNT staff and providers. Informal, soft, influencing actions have an impact on providers.* |
| **Informational** | *The QNT collates intelligence and puts information about provider performance into the public domain or shares it with other actors who then use it for decision-making (eg, commissioning, patient choice).* |
| **Stakeholder** | *Peer review actions encourage, mandate or influence other stakeholders to take action or to interact with the provider.* |
| **Lateral** | *Peer review interactions stimulate interorganisational interactions, such as providers working with their peers to share learning and undertake improvement work.* |
| **Systemic** | *Aggregated findings/ information from peer review are used to identify systemic or interorganisational issues, and to influence stakeholders and wider systems other than the providers themselves.* |